

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

**ORIGINAL**

PRINTED: 03/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/20/2014</b>
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY NEW UNDERWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761</b>
---------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 000	INITIAL COMMENTS  Surveyor: 28057 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/18/14 through 2/20/14. Good Samaritan Society New Underwood was found not in compliance with the following requirements: F364, F368, and F371.	F 000	<p><i>Addendums noted with an asterisk per 3/11/14 telephone to facility administrator. KG/SSDOH/MF</i></p> <p>On 2/19/14 and 3/3/14 the Dietary Manager (DM) educated Cook A, the Evening Cook, and the part time AM cook; on the requirement that a liquid with nutritive value needs to be added to thin pureed foods (altered textured diets).</p> <p>The Registered Dietician reviewed the attached procedure written by the DM which lists which foods are acceptable to be used for altering the texture of foods. Education will be given by the DM to all cooking staff before 3/19/14. A copy of the procedure will be posted in the kitchen for reference, all new cooks will be educated on the procedure, and a yearly in-service will be conducted. The DM will audit the cooks to ensure they are using the recommended nutritional liquids when alternating textured foods monthly x 3 and Quarterly x 3. Findings will be reported to the QA committee for further recommendations* by the dietary manager. KG/SSDOH/MF</p>	
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and policy review, the provider failed to ensure a liquid with nutritive value had been added to thin the pureed foods for two of two observed meal services (supper and noon). Findings include:  1. Observation on 2/18/14 from 5:15 p.m. through 6:35 p.m. of cook A while she pureed resident food for the supper meal service revealed she: *Put the corn into the blender. *Retrieved tap water from the sink and placed it into the microwave to heat it. *Poured the heated tap water into the blender to thin the corn.	F 364		* 4/11/14 KG/SSDOH/MF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Hongla Lake Quinn</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/14/14</i>
---------------------------------------------------------------------------------------------------	-------------------------------	-----------------------------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

MAR 17 2014  
SD DOH LSC

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY NEW UNDERWOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	<p>Continued From page 1</p> <p>2. Observation and interview on 2/19/14 at 11:00 a.m. with cook A while she pureed the resident food for the the noon meal service revealed she: *Put the peas into the blender. *Retrieved tap water from the sink and placed it into the microwave to heat it. *Poured the heated tap water into the blender to thin the peas.</p> <p>Interview with cook A at the time of the above observation revealed she always used water to thin the vegetables unless they didn't need extra fluid to blend them.</p> <p>Lisa Eckstein and Katheryn Adams, Pocket Resource for Nutritional Assessment, 2013 Ed., Chicago, IL., 2013, pp. 103 and 106, revealed for a resident with dysphagia (problems with swallowing) can result in serious health consequences as it can interfere with adequate nutrition and hydration. To minimize swallowing problems, and maximize nutrition, hydration, and quality of life for the resident, dietary modifications involve changes in food and/or liquid texture to help compensate for loss of function, to maintain appropriate nutritional and hydration status, and to reduce the risk of aspiration. These may include temperature changes and order of food/liquid presentation changes such as moistening and providing a cohesive bolus (to hold an amount together) by adding gravy or sauce.</p> <p>Review of the provider's August 2012 Texture Altered Diets policy revealed "Texture-altered diets will be served attractively and prepared by methods that conserve nutritive value, flavor and appearance."</p>	F 364		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY NEW UNDERWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 368 F 368 SS=E	Continued From page 2 <b>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME</b>  Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.  There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.  The facility must offer snacks at bedtime daily.  When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.  This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on interview and policy review, the provider failed to ensure a bedtime snack had been offered to every resident every night Findings include:  1. Group interview held on 2/19/14 at 9:00 a.m. with eleven residents present revealed bedtime snacks had not been offered every night to every resident.  Interview on 2/19/14 at 11:45 a.m. with certified nursing assistant B revealed: *He had worked both day and evening shifts. *Only one snack had been offered every day	F 368 F 368	On 2/20/14, via daily 'Nursing Updates' Staff was instructed that all Residents must be offered a HS Snack every evening; documentation must include whether the Resident accepted or refused a HS Snack or was asleep at the time of snack pass. Starting on 2/20/14, daily documentation was done by using a Resident report sheet; on 2/27/14, a form/audit was developed and explained to Nursing Staff. Addendum made to the procedure explaining, Residents will not be wakened in order to offer bedtime snacks; HS Snacks will be documented as "Accepted, Refused, Asleep" on every Resident daily on the HS Snack Audit. All Nursing Staff will be formally educated on the provision and delivery of bedtime snacks by 3/19/14.  DNS or Designee will audit weekly to ensure all Residents are being offered HS Snacks every evening and verification of documentation as to acceptance, refusal or asleep.  DNS or Designee will report findings monthly x 3, quarterly x 3 to the QA Committee for further recommendations.	* 4/11/14 K6/SDDH/MP	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY NEW UNDERWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 368	Continued From page 3 between 4:00 p.m. and 4:30 p.m. in the afternoon. *Bedtime snacks had not been offered.  Interview on 2/19/14 at 4:45 p.m. with the dietary manager revealed they had a prepared snack cart for bedtime snacks.  Interview on 2/20/14 at 9:00 a.m. with the director of nursing revealed bedtime snacks should have been offered to every resident every night.  Review of the provider's August 2012 Frequency of Meals and Snacks revealed "The center must offer snacks at bedtime daily."	F 368		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation and interview, the provider failed to ensure: *The walk-in cooler floor had remained free from a chipped and rusted surface. *The floor underneath the dishwasher was maintained in a clean and sanitary manner.	F 371	<p>Notify the department of health life safety code staff of the date for installation and the product used.</p> <p>a. The walk-in cooler floor will receive a new cleanable surface in 2014. On 2/20/14 the maintenance supervisor (MS) contacted the centers environmental consultant to discuss various flooring options for the walk-in cooler. A recommended installer will here on 3/17/14 to review the project and give us a quote for the flooring and installation.*</p> <p>b. The floor under the dishwasher was cleaned by the DM on 2/20/14. Proper cleaning instructions were given to the entire dietary department the week of 2/24-2/28 2014. Cleaning the floor underneath the dishwasher has been added to the dietary aides daily shift cleaning and mopping checklist.</p>	4/11/14 KF(SDDOH)ME

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/20/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY NEW UNDERWOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 4</p> <p>*Chemicals had been stored away from clean dishes. Findings include:</p> <p>1. Random observations from 2/18/14 through 2/19/14 in the kitchen revealed: *The walk-in cooler had a chipped and rusted surface that created an uncleanable surface (photo 3). *The floor underneath the dishwasher had dirt and debris on it (photo 4). *The clean dish rack had two bottles of cleaner hung on it that included Oasis 146 multi-quatarnary sanitizer and Pure bright disinfectant bleach (photo 5). The clean dish rack had clean dishes on it including silverware, cups, mugs and pitchers.</p> <p>Interview on 2/19/14 at 4:45 p.m. with the dietary manager revealed she agreed: *The walk-in cooler floor needed to be refinished. *The floor under the dishwasher should have been cleaned daily. *Chemicals should have been stored away from the clean dishes.</p>	F 371	<p>Continued From page 4</p> <p>The cooks and DM will check the floor underneath the dishwasher before the end of the dietary aide's shift. Findings will be reported to the QA committee for further recommendations* <i>by the dietary manager. KG/SDDH/MF</i></p> <p>c. The chemical spray bottles were removed from the clean dish rack on 2/20/14. Education was given to the entire dietary department the week of 2/24-2/28 2014 explaining why chemicals are to be stored away from clean dishes and food products. A sign was posted on the wire rack to remind staff that chemicals cannot be placed near clean dishes. An annual review will be conducted with the dietary staff on proper chemical storage. The DM will audit chemical storage in the kitchen monthly x 3 and quarterly x 3. Findings will be reported to the QA committee for further recommendations* <i>by the dietary manager. KG/SDDH/MF</i></p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

PRINTED: 03/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2014</b>
--------------------------------------------------	-------------------------------------------------------------------------	---------------------------------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY NEW UNDERWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761</b>
---------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

K 000	INITIAL COMMENTS  Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/19/14. Good Samaritan Society - New Underwood was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K046, K050, K064, K073, and K155 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 3/14/14 email from facility administrator. CKV/SDDOH/MF	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to ensure the emergency lighting at the generator set and power transfer switch were tested monthly and annually. Findings include:  1. Observation at 2:40 p.m. revealed a battery pack emergency light located above the power transfer switch for the generator in a shed next to the generator set. The generator set had two exterior lights for illumination on the outside of the shed. Interview with the maintenance supervisor (MS) at the time of the observation revealed he was not aware how to check those emergency	K 046	The emergency lighting at the generator set and the power transfer switch were tested on 2/20/14 and were added to the monthly and annual preventative maintenance schedule, requiring lights be tested for 30 minutes monthly and 90 minutes annually. Testing will be performed by maintenance personnel, monitored by the administrator, reported and audited by the QA Coordinator monthly x 3 and quarterly x 3.  *The QA coordinator will report to QA monthly. CKV/SDDOH/MF	*4/11/14 CKV/SDDOH/MF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Angela Lalo-Sumner</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3/14/14</i>
----------------------------------------------------------------------------------------------------	-------------------------------	-----------------------------

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY NEW UNDERWOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 046	Continued From page 1 lights. He stated he had never checked the battery back-up lights for the generator set or the transfer switch for the required 30 minutes monthly or the 90 minutes annually. The MS stated he had the emergency lights inside the facility on a preventive maintenance plan but not the generator lights.	K 046	
K 050 SS=B	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Surveyor. 20031 Based on record review and interview, the provider failed to provide adequate details for four of fourteen fire drills conducted from July 2013 through January 2014. Findings include:</p> <p>1. Review of the past fourteen fire drills conducted from 7/17/13 through 1/30/14 revealed: *7/17/13 - The fire drill report had the notation "sprinkler test". Interview with the maintenance supervisor (MS) at the time of the review revealed he had also used that sprinkler test as a fire drill. No information was provided to state where the drill was located, timing of the drill, staff response,</p>	K 050	<p>Fire drill reports will be completed in full, including location, time, staff response, if the drill was satisfactory, and any training that was conducted; before forwarding to the administrator. Fire drill reports will be reviewed in detail by the administrator before signing and audited by the QA Coordinator monthly x 3 and quarterly x 3.</p> <p>*The QA coordinator will report to QA monthly. CKV/SDDH/MF</p> <p>* 4/11/14 CKV/SDDH/MF</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY NEW UNDERWOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 2 and if the drill was satisfactory. *1/1/14 - The fire drill report had no time and no location. *1/3/14 - The fire drill report had no location. *1/30/14 - The fire drill report had no location.  Continued review of the other fire drill reports revealed there was incomplete information about staff response and training that was to have been conducted after failed fire drills.  Interview at 1:15 p.m. with the MS confirmed those findings. He stated he reviewed the drills and signed the report forms. But he revealed he was not aware the information on the fire drills was missing.	K 050		
K 064 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10  This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to perform monthly checks for fifteen of fifteen fire extinguishers in accordance with NFPA 10. Monthly checks had not been performed in January 2014. Findings include:  1. Random observation from 1:30 p.m. to 2:30 p.m. revealed all fifteen facility fire extinguishers did not have monthly maintenance checks performed in January. All extinguishers with the	K 064	Maintenance personnel will be conducting monthly maintenance checks on all fire extinguishers beginning with the March 2014 checks utilizing the monthly preventative maintenance schedule This schedule lists all fifteen fire extinguishers per facility location. The preventative maintenance schedule along with each fire extinguisher will be audited by the QA Coordinator monthly x 3 and quarterly x 3.  <i>x The QA coordinator will report to QA monthly. CKV/SDDH/MF</i>	<i>* 4/11/14 CKV/SDDH/MF</i>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY NEW UNDERWOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 064	Continued From page 3 exception of the two in the kitchen had been checked in February. The two in the kitchen did not have the monthly February check. Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated the commercial inspection had been done in December 2013 and the company was a month early. He had thought he did not have to check for January, as the company was actually supposed to come in January. He indicated he had apparently forgotten the extinguishers in the kitchen. He further revealed he did have a list of all extinguishers in his preventative maintenance plan. But, he stated he had used his memory when he completed his checks in February.	K 064	
K 073 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to prohibit the display of combustible materials on one of one doors to the activity room. The inside of that door was completely covered with blue paper. Findings include:</p> <p>1. Observation at 2:00 p.m. revealed the inside of the activity room door was completely covered with blue paper. Interview at the time of the observation with the maintenance supervisor confirmed that finding. He stated he was not aware that door was covered with paper. He revealed the activity person was new and may not know the door could not be covered with</p>	K 073	<p>On 2/19/14 all combustible materials (blue paper) were removed from the activity room door. On 2/20/14 all other egress doors throughout the facility were audited to ensure that combustible materials were not adhered to them. All staff members will be informed by 3/19/14 that adhering combustible materials to egress doors is prohibited. The QA Coordinator will add the egress door audit to her routine monthly audits.</p> <p><i>*The QA coordinator will report to QA monthly. CKV/SDDH/MF</i></p> <p><i>*4/1/14 CKV/SDDH/MF</i></p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY NEW UNDERWOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
K 073  K 155 SS=D	<p>Continued From page 4 decorations.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>This STANDARD is not met as evidenced by: Surveyor: 20031 Based on record review, policy review, and interview, the provider's fire alarm panel had been shut down from 12/30/13 through 1/3/14. The provider did not adequately complete the one hour fire watches as indicated in their policy and as documented on their fire watch forms. Findings include:</p> <p>1. Record review revealed two documents had been faxed to the South Dakota Department of Health (DOH). Those two documents informed the DOH when the provider's fire alarm panel was placed out of service, and when the fire alarm panel was placed back into service. Additional documents were the hourly fire watches that had been placed into effect. Review of the daily fire watches revealed: *12/31/13 - No watch was conducted for 4:00 p.m. *1/1/14 - No watch was conducted for 7:00 a.m. *1/2/14 - No watch was conducted for 5:00 a.m., 6:00 a.m., 7:00 a.m., 1:00 p.m., 2:00 p.m., and</p>	K 073  K 155	<p>In the event of a breakdown of the fire alarm system or any other situation where the integrity of the fire suppression or notification equipment is out of service; the fire watch procedure, forms, and documentation will be reviewed with all staff on duty at the time of the malfunction by the administrator, maintenance supervisor, and/or the director of nursing, continuing with all staff on subsequent shifts. Education on fire watch procedures, forms, and documentation will be provided during monthly fire drills on all shifts. The maintenance supervisor will audit fire watch rounds and documentation daily while the facility is on an active fire watch.</p> <p>*The QA coordinator will report to QA monthly. CKY/SDDOH/ME</p> <p>*4/11/14 CKY/SDDOH/ME</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435104</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - <b>MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/19/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY NEW UNDERWOOD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>412 SOUTH MADISON POST OFFICE BOX 327 NEW UNDERWOOD, SD 57761</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 155	Continued From page 5 3:00 p.m.  Interview at the time of the record review with the maintenance supervisor (MS) revealed he was not aware staff had not completed the hourly fire watches. The MS stated he was aware the fire watches must be completed hourly as required per code and per the provider's policy.	K 155		

ORIGINAL

PRINTED: 03/03/2014  
FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10657</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/20/2014</b>
--------------------------------------------------	------------------------------------------------------------------------	------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER <b>GOOD SAMARITAN SOCIETY NEW UNDERWOOD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>412 S MADISON PO BOX 327 NEW UNDERWOOD, SD 57761</b>
-----------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

S 000	<p>Initial Comments</p> <p>Surveyor: 28057 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/18/14 through 2/20/14. Good Samaritan Society New Underwood was found in compliance.</p>	S 000		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Angela Lutz - Zumm* ADMINISTRATOR **RECEIVED** MAR 17 2014

STATE FORM 021199 E00211 If continuation sheet 1 of 1  
SD DOH L&C